D2.01 Comprehensive rehabilitation intervention research–Rehabilitation service evaluation (including acute, post-acute and community rehabilitation services)

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Rehabilitation capacity-building in developing countries

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Introduction/Background Despite the prevalence of disability in low-and-middle income countries (LMICs), the clinical skills of rehabilitation workforce are not well described. We report health professionals' perspectives on clinical skills in austere settings and identify context-specific gaps for workforce capacity.
Material and method An exploratory-descriptive, cross-sectional, pilot survey of healthcare professionals working in rehabilitation in hospital and community settings conducted in Pakistan, Morocco, Nigeria and Malaysia. A situational-analysis survey-tool captured cross-sectional assessment of clinical skills required in various rehabilitation settings. Participant responses were coded in a line-by-line process, and clustered into common terms based on International Classification of Functioning, Disability and Health (ICF) framework to classify skill-categories in target domains.
Results Survey respondents ($n = 532$) from Pakistan 248, Nigeria 159, Morocco 93 and Malaysia 32 completed the survey. The participants were: physiotherapists (52.8%), nurses (8.8%), speech and occupational therapists (8.5%, 5.3%), other medical doctors (5.5%), rehabilitation physicians (3.8%), and prosthetist/orthotists (1.5%). The 10 most commonly used clinical skills reported were prescription of physical activity and medications, transfer-techniques, daily-living activities, allied health interventions, patient/carer education, comprehensive patient-care, diagnosis/screening, behaviour/cognitive interventions, referrals, assessments and collaboration. Most responses linked with ICF categories in activities/participation, and personal factors.
Conclusion The survey tool identified task shifting amongst healthcare professionals. The core skills and gaps reflected general rehabilitation practice, rather than discipline-specific skills.
Keywords Rehabilitation; Capacity-building; Low-and-middle income countries
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Quality in dementia care: A cross sectional study on the bio-psycho-social competencies of health care professionals

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Introduction/Background Professionals in dementia-care ought to be able to work within a Bio-Psycho-Social model. The objectives were to examine whether dementia-care is delivered in a Bio-Psycho-Social way, to explore the influencing factors and to evaluate the factorial validity of the 'Bio-Psycho-Social-Dementia-Care scale'.
Material and method 413 healthcare-professionals completed the 'Bio-Psycho-Social-Dementia-Care scale'. Differences between groups (settings, professions, years of experience) were calculated with a student's *t*-test and one-way ANOVA. The facture structure of the scale was evaluated using a confirmatory factor analysis.
Results The factor-analysis confirmed the 5 subscale-structure (1) networking, (2) using the client's expertise, (3) assessment and reporting, (4) professional knowledge and skills and (5) using the environment. (No significant differences were found between professionals in residential care and community care for the subscales 'networking' and 'using the client's expertise'. Professionals in residential care score higher than community care for 'assessment and reporting' ($P < 0.05$) and 'professional knowledge and skills' ($P < 0.01$) but lower for 'using the environment' ($P < 0.001$). The juniors score higher for 'professional knowledge' compared to seniors ($P < 0.01$) and the seniors score better for 'professional experience' ($P < 0.01$). The Cure and Care disciplines and the Therapy disciplines had higher values in 'assessment and reporting' compared to the Social Support disciplines ($P < 0.001$ and $P < 0.001$). The Therapy disciplines scored higher in 'using professional knowledge and skills' compared to the Social Support group ($P = 0.021$) and the Cure and Care disciplines ($P < 0.001$). The Social Support disciplines scored higher in 'using the environment' compared to the Therapy disciplines ($P < 0.001$) and the Cure and care disciplines ($P < 0.001$).
Conclusion The Bio-Psycho-Social-Dementia-scale is a valid tool and offers opportunities not only to rate, but also to improve Bio-Psycho-Social functioning in dementia-care: increase interdisciplinary collaboration, facilitate assessment, combine the strengths of the different professions and install a heterogeneous team with regard to age and experience.
Keywords Dementia care; Measurement tool; Bio-psycho-social model
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